IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

August 8, 2006

Lisa Junod, Administrator
1970 East 17th Street #103
Idaho Falls, ID 83404

License #: RC-693

Dear Ms. Junod:

On July 6, 2006, a complaint investigation survey was conducted at Rosetta Assisted Living - Delphic. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.
- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted plan of correction and evidence of resolution.

Should you have questions, please contact Rebecca Winter, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

REBECCA WINTER
Team Leader
Health Facility Surveyor
Residential / Assisted Living Program

RW/slc

c: Jamie Simpson, BS, QRMP, MBA, Supervisor, Residential Community Care Program

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FILE COPY

July 20, 2006

Lisa Junod, Administrator
1970 East 17th Street #103
Idaho Falls, ID 83404

Dear Ms. Junod:

On July 6, 2006, a complaint investigation survey was conducted at Rosetta Assisted Living - Delphic. The survey was conducted by Rebecca Winter, R.N. and Polly Watt-Geier, LSW. This report outlines the findings of our investigation.

Complaint # ID00001494

Allegation #1: The facility failed to obtain emergency services for the identified resident.

Findings: Based on observation, interview, and record review it was determined the facility failed to obtain emergency services for the identified resident.

On Jun 27, 2006 the facility's policy and procedure for "Medical Emergencies" were reviewed. The policy stated "emergency medical care is administered immediately" in the case of major emergency. The policy also stated the caregivers would immediately call 911. The facility's policy also contained a list of examples of major emergencies, which included "sudden, severe pain anywhere in the body, and any trauma to the head."

Review of Resident #1's record on Jun 21, 2006 revealed the resident was admitted on December 23, 2006 with diagnoses which included hypertension, dyspnea, dyspepsia, diverticulitis, osteoporosis, and osteoarthritis.

The resident's record contained a combined UAI/NSA dated June 15, 2006. Under the section entitled "Emergency Response" it was documented the resident required total physical and verbal assistance to get out of the facility or to obtain emergency help. Under the section entitled "Skin Care" it was documented the resident had

multiple bruising related to falls and was to be monitored for new bruises.

The resident's record contained an "Observation Chart" that was reviewed on June 16, 2006 on which caregivers documented checking the resident every fifteen minutes. The documentation started on June 1, 2006 and continued through the date the record was reviewed. Even though there was documented evidence of fifteen minute checks the resident continued to fall.

Review of the facility's incident and accident reports on Jun 21, 2006 revealed documentation of the following incidents for Resident #1:

On May 27, 2006 (untimed) a caregiver documented she noticed bruising in the pelvic area at about 4:30 p.m. The caregiver also documented the resident "fell over while trying to get on the couch."

On May 29, 2006 at 5:30 p.m. another caregiver documented she noticed unusual purple and red discoloration on the resident's vaginal area. The administrator documented on this form below the caregiver's notation "the bruise is on the resident's perineal/groin area."

On May 30, 2006 at 8:30 a.m. the resident was standing at the sink brushing her teeth and "she turned around and fell over on her face."

On May 31, 2006 at 3:58 a.m. the caregiver heard a thud and the resident was found on the "possible bruising on her legs."

On June 5, 2006 at 8:30 a.m. during routine rounds the resident was found on the floor, "lying on her back and her head was resting on the wall."

On June 11, 2006 at 8:30 a.m. the resident attempted to stand from her wheel chair and fell forward. The resident had bruising over her left eye.

Further review of the resident's record on Jun 21, 2006 revealed "Progress Notes" that documented the following:

On March 1, 2006 (untimed) resident said she fell out of bed and "she had a couple of marks on her face."

On May 31, 2006 at 8:30 a.m. the resident fell when she attempted to get out of bed, and she hit her head on the roommate's bed frame. The documentation indicated this occurred the previous night.

On June 13, 2006 (untimed) the resident fell on June 11, 2006 (untimed) when she tried to stand up and fell forward, the resident struck the right side of her head and eye.

Review of the resident's record on Jun 21, 2006 revealed no documented evidence the facility obtained emergency services or medical attention for the resident.

The resident's record contained an assessment by the facility's nurse dated May 31, 2006, in which the nurse documented the resident fell two times on May 30, 2006, had a golf ball size hematoma on the left elbow, and had two abrasions above the right eyebrow. In the recommendations section of the assessment the nurse documented the resident was a high fall risk and the mattress and box springs were to be placed on the floor. The nurse further documented she had discussed the resident's case with the hospice nurse and with the physician.

Further review of the resident's record on Jun 21, 2006 revealed a physician's order dated April 14, 2006 for a hospice care evaluation.

Review of the resident's hospice nurse's notes and phone records on Jun 21, 2006 revealed the following documentation:

On May 5, 2006 at 9:00 a.m. the resident had an 8 cm area of dark purple bruising on the left buttocks that continued down the left leg, which was approximately 11 cm and also dark purple. On May 8, 2006 at 2:00 p.m. there was "new bruising on the patient's left popliteal area" measuring approximately 9 cm.

On May 30, 2006 at 12:15 p.m. the hospice nurse documented he had been notified that morning the resident fell. The assessment form used by the nurse contained a diagram of a human body. On the body diagram the nurse indicated the resident had dark purple bruising of 11 to 12 cm in diameter. The suprapubic area and the mons pubis areas were circled on the diagram.

On May 30, 2006 at 1:45 p.m. the hospice nurse phoned the resident's daughter and told her the resident had fallen and had "sustained bruising from lower pubis (vaginal area) to upper mid-abdomen at size 11 to 12 cms."

On May 31, 2006 at 8:45 a.m. the hospice nurse noted the resident had fallen again the night before and had new bruising. The body diagram on the assessment form indicated there was bruising to the left eyelid, bruising to the lip, light red bruising to the right arm of 1.5 cm.

On June 1, 2006 at 12:30 p.m. the resident complained of severe back pain, to include back pain with sitting position, turning of torso, or any movement involving

lower back movement. The body diagram on the assessment form indicated a 2 by 1 cm bruise above the right eye, a 3.5 cm bruise in the left corner of the right eye, a 2 cm diameter bruising on the right side of the right eye, bruising and inflammation to the left upper lip, and a 9 by 4 cm bruise to left upper lateral leg. The abdominal and groin bruising remained at 12 cm. and was dark purple in the groin area and light yellow on the abdomen.

On June 5, 2006 at 12:30 p.m. the hospice nurse noted the resident had had a fall that morning. The body diagram on the assessment form indicated a new bruise above the right breast about 6 cm. in diameter that was light purple in color.

On June 12, 2006 at 11:00 a.m. the hospice nurse noted the resident fell on June 8, 2006 and June 10, 2006. The body diagram on the assessment form indicated a 1 by 11 cm bruising on the left forehead, a "40 by 35 cm bruising" on the left elbow, a 3 cm bruise on the left back in the scapular area, a 10 cm bruise over the left knee, a 4 cm bruise on the right mid-thigh area, an 8 cm bruising on the left hip, and a 6 cm bruising on the left hip in the external femur area. The nurse also documented the resident had a laceration on her left elbow that was described as a "stage II" of 1 by 6 cm.

On June 16, 2006 at 10:15 a.m. the resident was observed sitting in a wheel chair at the dining room table. She had a tab alarm attached from the back of the chair to her shirt. The resident attempted three or four times to stand up from her chair within about 30 minutes, and each time the tab alarm sounded. She was also observed calling out frequently and loudly for someone to, "Get me out of here." Two staff were present during the observation, and the resident required frequent attention from a caregiver.

On June 16, 2006 at 10:05 a.m., a caregiver stated the resident fell often and had a bruise that ran from her torso down to her pelvic area. She stated the resident was not evaluated by a physician, however hospice had been notified.

On June 16, 2006 at 10:22 a.m., the house manager stated the hospice RN had evaluated the resident's bruising after the resident fell.

On June 16, 2006 at 11:00 a.m., a caregiver stated on May 27, 2006 she had taken the resident to the bathroom before dinner, as the resident stood up from the toilet she observed the bruising on the resident's pelvic area. She said the bruise was tan, blue, and red in color. She stated the bruise was located "below the stomach in the pelvic area where there was a crease by the hip." She further stated the bruising looked like it stopped at the hairline and did not go down into the vaginal area. She stated she had worked two days earlier and the resident had no bruises at that time.

On Jun 21, 2006 at 10:48 a.m., a resident's family member stated she was aware the resident had had many falls. She stated the hospice nurse and the facility's nurse evaluated the resident after each fall.

On Jun 21, 2006 at 11:17 a.m., a hospice aide stated the resident was unsteady, and she thought the resident was a fall risk. She stated the resident was found with bruising on her pelvis and abdomen area on May 30, 2006. She stated the resident was not assessed by a physician, but the hospice nurse had assessed the bruising.

On Jun 21, 2006 at 2:03 p.m., the administrator stated she was notified of the resident's bruising on the pelvic area on May 30, 2006, three days after the bruising was initially observed. She further stated the hospice nurse had assessed the bruising and contacted the resident's primary physician about the resident's condition.

On June 22, 2006 at 10:00 a.m., the hospice RN stated the resident had fallen seven times since the end of April. He stated the resident had bruising on her abdomen and pelvic area that was approximately 13 centimeters and was dark purple in coloration. He stated that after assessing the bruising, he faxed information to the resident's primary physician and had received no response.

On June 22, 2006 at 1:10 p.m., the facility RN stated the facility had been working with the resident to decrease her fall risk. She stated the facility had notified her of the resident's falls and she had been in to assess the resident, but let the hospice nurse assess and relay the information to the physician.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for inadequate care. The facility was required to submit a plan of correction.

Allegation #2: The facility failed to notify the Department of reportable incidents.

Findings: Based on interview and record review it was determined the facility failed to notify the department of reportable incidents.

Review of the facility's incident and accidents on June 16, 2006 revealed the following:

On June 5, 2006 at 8:30 a.m. the identified resident was found on the floor with her head resting on the wall.

On June 8, 2006 at 2:45 a.m. the identified resident was found on the floor by the rocking chair in the resident's room. The resident had a scrape on her left elbow.

On June 9, 2006 between 8:00 a.m. and 8:30 a.m. a random resident had an unobserved fall. The resident had a bruise on her head and a bruise on her knee.

On June 10, 2006 at 10:45 p.m. a random resident fell backward and hit his head on the wall.

On June 11, 2006 at 8:30 a.m. the identified resident attempted to stand from her wheel chair and fell forward. The resident had bruising over her left eye.

On June 16, 2006 at 10:20 a.m., the house manager confirmed not all reportable incidents were reported to the department within twenty-four hours.

On Jun 21, 2006 at 2:03 p.m., the administrator confirmed not all reportable incidents were reported to the the department within twenty-four hours.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.07 for not reporting reportable incidents to the department. The facility is required to submit evidence of resolution within 30 days.

Based on the findings of the complaint investigation, the facility was found to be out of compliance with the rules for Residential Care or Assisted Living Facilities in Idaho. A Statement of Deficiencies has been issued to your facility. Please develop a Plan of Correction as outlined in the cover letter to the Statement of Deficiencies. AND/OR Non-core issues were identified and included on the Punch List.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

REBECCA WINTER
Team Leader
Health Facility Surveyor
Residential Community Care Program

RW/slc

c: Jamie Simpson, BS, QRMP, MBA, Supervisor, Residential Community Care Program

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July 20, 2006

CERTIFIED MAIL #: 7003 0500 0003 1967 0124

Lisa Junod, Administrator
1970 East 17th Street #103
Idaho Falls, ID 83404

FILE COPY

Dear Ms. Junod:

Based on the complaint investigation survey conducted by our staff at Rosetta Assisted Living - Delphic on **July 6, 2006,** we have determined that the facility failed to protect residents from inadequate care.

This core issue deficiency substantially limits the capacity of Rosetta Assisted Living - Delphic to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **August 17, 2006.** **We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us by **August 2, 2006,** and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Chief of the Bureau of Facility Standards for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**August 2, 2006**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for the Bureau of Facility Standards to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **August 2, 2006,** your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **August 5, 2006**.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Rosetta Assisted Living - Delphic.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, BS, QRMP, MBA
Supervisor
Residential Community Care Program

JS/slc

Enclosure

c: Debra Ransom, R.N., R.H.I.T., Chief, Bureau of Facility Standards
Karen Vasterling, Program Manager, Regional Medicaid Services, Region VI - DHW

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R693	A. BUILDING _____ B. WING _____	C 07/06/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSETTA ASSISTED LIVING - DELPHIC	1590 DELPHIC WAY POCATELLO, ID 83204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments The following deficiency was cited during the complaint investigation conducted at your residential care/assisted living facility on 7/6/06. The surveyors conducting your survey were: Rebecca Winter, RN Team Leader Health Facility Surveyor Polly Watt-Geier, LMSW Health Facility Surveyor Survey Definitions: NSA = Negotiated Service Agreement UAI = Uniform Assessment Instrument cm = centimeters APS = Adult Protection Services	R 000		
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to obtain emergency services and retained a resident for whom the facility did not have the capability, capacity, and services to provide appropriate care. These failures resulted in inadequate care for 1 of 1 resident reviewed (Resident #1). The findings include: I. Emergency Services	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R 008	Continued From page 1 On 6/27/06 the facility's policy and procedure for "Medical Emergencies" were reviewed. The policy stated "emergency medical care is administered immediately" in the case of major emergency. The policy also stated the caregivers would immediately call 911. The facility's policy also contained a list of examples of major emergencies, which included "sudden, severe pain anywhere in the body, and any trauma to the head." Review of Resident #1's record on 6/21/06 revealed the resident was admitted on 12/23/06 with diagnoses which included hypertension, dyspnea, dyspepsia, diverticulitis, osteoporosis, and osteoarthritis. The resident's record contained a combined UAI/NSA dated 6/15/06. Under the section entitled "Emergency Response" it was documented the resident required total physical and verbal assistance to get out of the facility or to obtain emergency help. Under the section entitled "Skin Care" it was documented the resident had multiple bruising related to falls and was to be monitored for new bruises. The resident's record contained an "Observation Chart" that was reviewed on 6/16/06 on which caregivers documented checking the resident every fifteen minutes. The documentation started on 6/1/06 and continued through the date the record was reviewed. Even though there was documented evidence of fifteen minute checks the resident continued to fall. Review of the facility's incident and accident reports on 6/21/06 revealed documentation of the following incidents for Resident #1:	R 008		

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R 008	Continued From page 2 On 5/27/06 (untimed) a caregiver documented she noticed bruising in the pelvic area at about 4:30 p.m. The caregiver also documented the resident "fell over while trying to get on the couch." On 5/29/06 at 5:30 p.m. another caregiver documented she noticed unusual purple and red discoloration on the resident's vaginal area. The administrator documented on this form below the caregiver's notation "the bruise is on the resident's perineal/groin area." On 5/30/06 at 8:30 a.m. the resident was standing at the sink brushing her teeth and "she turned around and fell over on her face." On 5/31/06 at 3:58 a.m. the caregiver heard a thud and the resident was found on the floor. The resident told staff she fell. The resident had a bruise over her left eye, and "possible bruising on her legs." On 6/5/06 at 8:30 a.m. during routine rounds the resident was found on the floor, "lying on her back and her head was resting on the wall." On 6/11/06 at 8:30 a.m. the resident attempted to stand from her wheel chair and fell forward. The resident had bruising over her left eye. Further review of the resident's record on 6/21/06 revealed "Progress Notes" that documented the following: On 3/1/06 (untimed) resident said she fell out of bed and "she had a couple of marks on her face." On 5/31/06 at 8:30 a.m. the resident fell when she attempted to get out of bed, and she hit her	R 008		

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R 008	Continued From page 3 head on the roommate's bed frame. The documentation indicated this occurred the previous night. On 6/13/06 (untimed) the resident fell on 6/11/06 (untimed) when she tried to stand up and fell forward, the resident struck the right side of her head and eye. Review of the resident's record on 6/21/06 revealed no documented evidence the facility obtained emergency services or medical attention for the resident. The resident's record contained an assessment by the facility's nurse dated 5/31/06, in which the nurse documented the resident fell two times on 5/30/06, had a golf ball size hematoma on the left elbow, and had two abrasions above the right eyebrow. In the recommendations section of the assessment the nurse documented the resident was a high fall risk and the mattress and box springs were to be placed on the floor. The nurse further documented she had discussed the resident's case with the hospice nurse and with the physician. Further review of the resident's record on 6/21/06 revealed a physician's order dated 4/14/06 for a hospice care evaluation. Review of the resident's hospice nurse's notes and phone records on 6/21/06 revealed the following documentation: On 5/5/06 at 9:00 a.m. the resident had an 8 cm area of dark purple bruising on the left buttocks that continued down the left leg, which was approximately 11 cm and also dark purple.	R 008		

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R 008	Continued From page 4 On 5/8/06 2:00 p.m. there was "new bruising on the patient's left popliteal area" measuring approximately 9 cm. On 5/30/06 at 12:15 p.m. the hospice nurse documented he had been notified that morning the resident fell. The assessment form used by the nurse contained a diagram of a human body. On the body diagram the nurse indicated the resident had dark purple bruising of 11 to 12 cm in diameter. The suprapubic area and the mons pubis areas were circled on the diagram. On 5/30/06 at 1:45 p.m. the hospice nurse phoned the resident's daughter and told her the resident had fallen and had "sustained bruising from lower pubis (vaginal area) to upper mid-abdomen at size 11 to 12 cms." On 5/31/06 at 8:45 a.m. the hospice nurse noted the resident had fallen again the night before and had new bruising. The body diagram on the assessment form indicated there was bruising to the left eyelid, bruising to the lip, light red bruising to the right arm of 1.5 cm. On 6/1/06 at 12:30 p.m. the resident complained of severe back pain, to include back pain with sitting position, turning of torso, or any movement involving lower back movement. The body diagram on the assessment form indicated a 2 by 1 cm bruise above the right eye, a 3.5 cm bruise in the left corner of the right eye, a 2 cm diameter bruising on the right side of the right eye, bruising and inflammation to the left upper lip, and a 9 by 4 cm bruise to left upper lateral leg. The abdominal and groin bruising remained at 12 cm. and was dark purple in the groin area and light yellow on the abdomen.	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ROSETTA ASSISTED LIVING - DELPHIC	1590 DELPHIC WAY POCATELLO, ID 83204

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R 008	Continued From page 5 On 6/5/06 at 12:30 p.m. the hospice nurse noted the resident had had a fall that morning. The body diagram on the assessment form indicated a new bruise above the right breast about 6 cm. in diameter that was light purple in color. On 6/12/06 at 11:00 a.m. the hospice nurse noted the resident fell on 6/8/06 and 6/10/06. The body diagram on the assessment form indicated a 1 by 11 cm bruising on the left forehead, a "40 by 35 cm bruising" on the left elbow, a 3 cm bruise on the left back in the scapular area, a 10 cm bruise over the left knee, a 4 cm bruise on the right mid-thigh area, an 8 cm bruising on the left hip, and a 6 cm bruising on the left hip in the external femur area. The nurse also documented the resident had a laceration on her left elbow that was described as a "stage II" of 1 by 6 cm. On 6/16/06 at 10:15 a.m. the resident was observed sitting in a wheel chair at the dining room table. She had a tab alarm attached from the back of the chair to her shirt. The resident attempted three or four times to stand up from her chair within about 30 minutes, and each time the tab alarm sounded. She was also observed calling out frequently and loudly for someone to, "Get me out of here." Two staff were present during the observation, and the resident required frequent attention from a caregiver. On 6/16/06 at 10:05 a.m., a caregiver stated the resident fell often and had a bruise that ran from her torso down to her pelvic area. She stated the resident was not evaluated by a physician, however hospice had been notified. On 6/16/06 at 10:22 a.m., the house manager stated the hospice RN had evaluated the resident's bruising after the resident fell.	R 008		

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	13R693	A. BUILDING _____ B. WING _____	C 07/06/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSETTA ASSISTED LIVING - DELPHIC	1590 DELPHIC WAY POCATELLO, ID 83204

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R 008	Continued From page 6 On 6/16/06 at 11:00 a.m., a caregiver stated on 5/27/06 she had taken the resident to the bathroom before dinner, as the resident stood up from the toilet she observed the bruising on the resident's pelvic area. She said the bruise was tan, blue, and red in color. She stated the bruise was located "below the stomach in the pelvic area where there was a crease by the hip." She further stated the bruising looked like it stopped at the hairline and did not go down into the vaginal area. She stated she had worked two days earlier and the resident had no bruises at that time. On 6/21/06 at 10:48 a.m., a resident's family member stated she was aware the resident had had many falls. She stated the hospice nurse and the facility's nurse evaluated the resident after each fall. On 6/21/06 at 11:17 a.m., a hospice aide stated the resident was unsteady, and she thought the resident was a fall risk. She stated the resident was found with bruising on her pelvis and abdomen area on 5/30/06. She stated the resident was not assessed by a physician, but the hospice nurse had assessed the bruising. On 6/21/06 at 2:03 p.m., the administrator stated she was notified of the resident's bruising on the pelvic area on 5/30/06, three days after the bruising was initially observed. She further stated the hospice nurse had assessed the bruising and contacted the resident's primary physician about the resident's condition. On 6/22/06 at 10:00 a.m., the hospice RN stated the resident had fallen seven times since the end of April. He stated the resident had bruising on	R 008		

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R 008	Continued From page 7 her abdomen and pelvic area that was approximately 13 centimeters and was dark purple in coloration. He stated that after assessing the bruising, he faxed information to the resident's primary physician and had received no response. On 6/22/06 at 1:10 p.m., the facility RN stated the facility had been working with the resident to decrease her fall risk. She stated the facility had notified her of the resident's falls and she had been in to assess the resident, but let the hospice nurse assess and relay the information to the physician. II. Appropriate Retention of a Resident Review of the combined UAI/NSA dated 6/15/06 revealed documentation under the section entitled "Ambulation/Transfer" the resident required physical help from staff to ambulate, was totally dependent on staff for transfers, and had numerous falls Further review of the combined UAI/NSA revealed interventions the caregivers were to use to prevent falls included the following: Tab alarm at all times Bed on floor Sit with the resident Talk with the resident Bring the resident into the living room near staff Every 15 to 30 minute checks at night Give the resident a pillow to hug The resident's record contained progress notes in which the following was documented: On 5/31/06 at 8:30 a.m. planned interventions	R 008		

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R 008	Continued From page 8 noted were to put the bed on the floor and to use a bed alarm. On 6/20/06 at 4:50 p.m. the resident had two more falls over the weekend, despite having the tab alarm. Review of the resident's hospice nurse's notes on 6/21/06 revealed the following documentation: On 5/31/06 at 8:45 a.m. planned interventions included using a tab alarm, moving the mattress and box springs to the floor, and obtaining a wheel chair for the resident. On 6/12/06 at 11:00 a.m. caregivers were instructed by the hospice nurse to use a two person assist with transfers. On 6/16/06 at 10:05 a.m., a caregiver stated the facility had put in place fall prevention measures that included two staff members on at the same time, a tab alarm, and the resident's bed was placed on the floor with a mattress beside it to prevent further injuries. On 6/16/06 at 10:22 a.m., the house manager stated the resident had been placed on fifteen minute checks, a tab alarm string was shortened to be more effective, and a pressure alarm had been ordered to help reduce resident's fall risk potential. On 6/16/06 at 11:00 a.m., a caregiver stated the facility had implemented fall prevention measures that included a tag alarm, placed the resident's bed on the floor, increased visits by the hospice aide and nurse. She also stated the hospice nurse had instructed the staff to increase fluid intake and place pillows between the resident's	R 008		

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R 008	Continued From page 9 legs to reduce bruising. She stated the facility had begun to have two caregivers on duty at one time to help the resident transfer and caregivers were to use a gait belt for transfers. On 6/21/06 at 10:48 a.m., a resident's family member stated the facility had placed fall preventative measures in place that included a tag alarm. On 6/21/06 at 11:17 a.m., a hospice aide stated the resident was a high level of care and a two person assist. She said the facility began using a wheelchair after she injured her pelvic region. On 6/21/06 at 2:03 p.m., the administrator stated the facility has put fall preventive measures in place that included fifteen minute checks on the resident and a pressure pad had been ordered. On 6/22/06 at 10:00 a.m., the hospice RN stated the resident's medication was changed to reduce hypotension, and fall prevention measures were put into place that included a tab alarm. He stated facility staff were initially checking the resident every two hours, but after the fall the resident had been placed on fifteen minute checks. On 7/6/06 at 2:36 p.m., the ombudsman stated the area agency on aging was notified on 5/30/06 at 12:51 p.m., by the facility administrator of the resident's pelvic and abdominal bruising. She stated that she and an APS worker visited the facility on 6/1/06 at 11:40 a.m. At that time, the ombudsman and APS worker discussed fall prevention measures for the facility to try with the resident. The facility implemented 15 minute checks, a tab alarm, placed the resident's bed on the floor with a mattress beside it, and monitored the resident's blood pressure. She also stated on	R 008		

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R 008	Continued From page 10 6/21/06 at 11:10 she and the APS worker re-visited the facility and found the resident beside the mattress on the floor yelling for assistance. She stated the staff member did not respond to the resident, even though another caregiver was on duty to assist with a two person transfer. Review of the facility's incident and accident reports, the resident's record, and the hospice nurses' notes revealed documentation the resident had thirteen falls over the course of her stay at the facility on the following dates: 1/31/06, 2/27/06, 3/1/06, 4/27/06, 5/27/06, 5/30/06 (two times), 5/31/06, 6/5/06, 6/8/06, 6/11/06, 6/18/06, 6/19/06. The facility failed to obtain emergency medical services for Resident #1 when the resident complained of severe pain, had injuries to her head, and had significant bruising. The facility retained Resident #1, for whom the facility did not have the capability, capacity, and services to provide appropriate care, when the resident continued to fall and fell with greater frequency, despite the measures put into place to prevent falls. These failures resulted in inadequate care.	R 008		

IDAHO DEPARTMENT OF HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name	Physical Address	Phone Number
Rosetta Assisted Living - Delphic	1590 Delphic Way	(208) 238-9215
Administrator	**City**	**ZIP Code**
Linda Miller	Pocatello	83404
Survey Team Leader	**Survey Type**	**Survey Date**
Rebecca Winter, RN	Complaint Investigation	7/6/06

NON-CORE ISSUES

ITEM #	RULE #	DESCRIPTION	DATE RESOLVED
1	16.03.22.350.07	The facility's administrator or designee did not notify the licensing and survey agency within twenty-four hours when reportable incidents occurred	

Response Required Date	Signature of Facility Representative
8/6/06	